

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00827

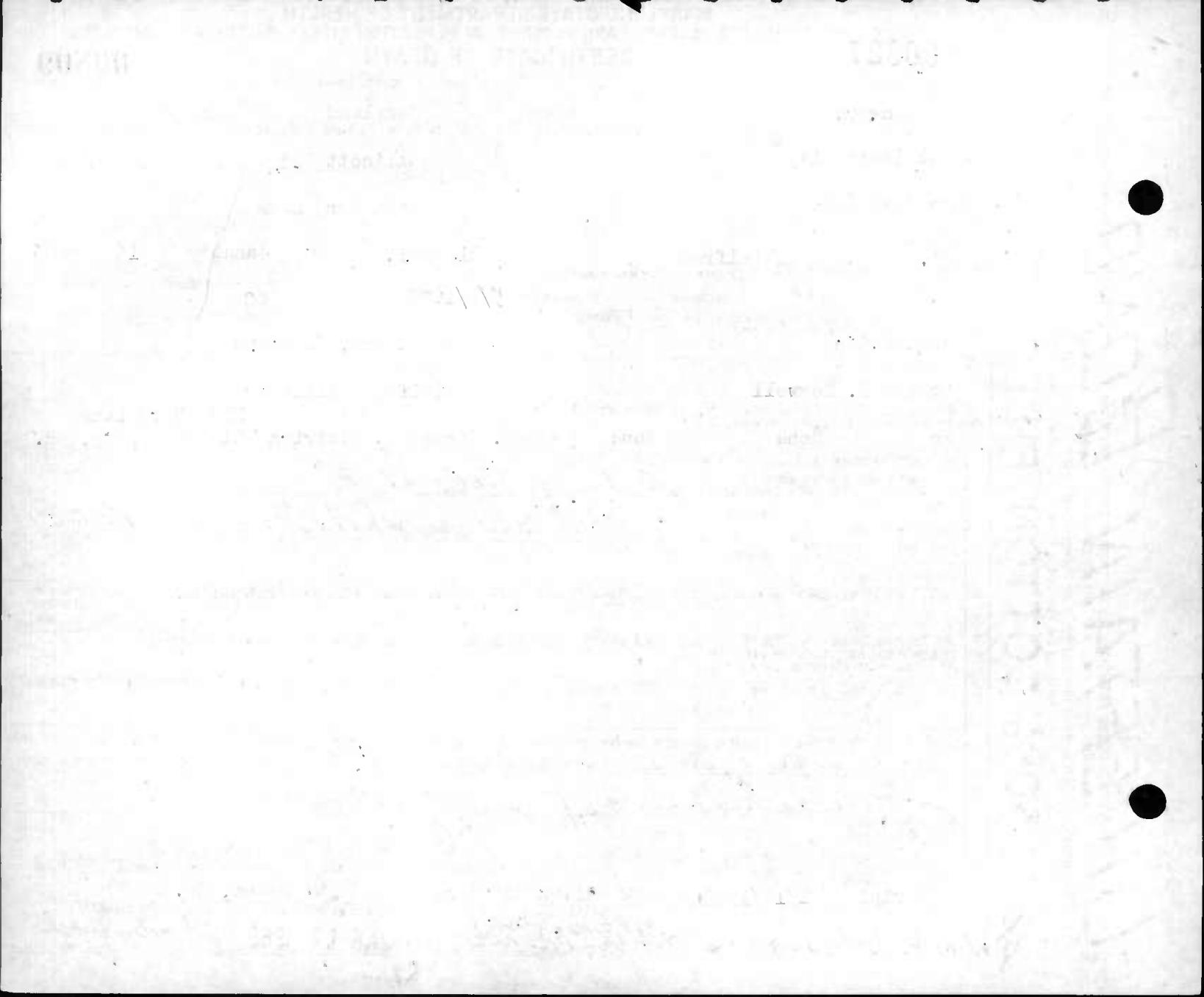
CERTIFICATE OF DEATH

101819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shep Herd Lane		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS Shep Herd Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Winifred		First	Middle	Last	4. DATE OF DEATH January 16 1966	Month	Day	Year			
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/4/1905	9. AGE (in years last birthday) 60 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Edward T. Boswell		14. MOTHER'S MAIDEN NAME Winifred Dillinger									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Horace W. Dietrich		Address Shep Herd Lane Ellicott City, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1538		C. a. of Colon c generalized metastasis 16 now									
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.		OUE TO (b)	OUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 9-28, 1964 to 1-16, 1966 that (I) (we) last saw the deceased alive on 1-16 1966 and that death occurred at 1157 M, from the causes and on the date stated above.		22b. DATE SIGNED									
22a. SIGNATURE James S. Bowes Jr.		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> M.D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>									
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS Belvoir 28									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1/19/1966		23c. NAME OF CEMETERY OR CREMATORIAL Woodlawn Cemetery		23d. LOCATION (City, town or county) (State) Woodlawn, Md.					
24. FUNERAL DIRECTOR Wm. J. Dietrich & Sons		ADDRESS Baltimore, Md. North & Pa. avs.		25a. REC'D BY REGISTRAR DATE JAN 17 1966		25b. REGISTRAR'S SIGNATURE Charles Judge					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00828

CERTIFICATE OF DEATH

00810

1. PLACE OF DEATH

a. COUNTY

Howard

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

Lisbon (Rural)

c. LENGTH OF STAY IN 1b

50 years

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

Rt. 2 - woodbin

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

John Wesley Dorsey

4. SEX

Male

6. COLOR OR RACE

Colored

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. DATE OF BIRTH

March 13, 1876

9. AGE (In years
last birthday)89
yrs.

10. UNDER 1 YEAR

Months

Dey

11. UNDER 24 HRS.

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

214-20-3538

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY,
IMMEDIATE CAUSE (a)

Arterio sclerotic Cardiovascular Disease

INTERVAL BETWEEN
ONSET AND DEATH

15-20 yrs

4221

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY
PERFORMED?YES NO

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 1b.)

20c. TIME OF INJURY
Hour a.m.
p.m.20d. INJURY OCCURRED
While at work Not While at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that (I) (this hospital) attended the deceased from....., 1958 to....., 1966, that (I) (we) last
saw the deceased alive on....., 1966, and that death occurred at....., 4 P.M., from the causes and on the date stated above.

22e. SIGNATURE

W.B. Culwell

M.D.

ATTENDING
PHYS.MED.
DIRECTORSTAFF
PHYS. 22b. DATE
SIGNED

Jan 28, 1966

22c. PHYSICIAN'S
NAME (Type)

W.B. Culwell

22d. ADDRESS

900 So Main St. Mt Airy, Md

23a. BURIAL, CREMATION,
REMOVAL (Specify)

Burial

23b. DATE THEREOF

2-4-66

23c. NAME OF CEMETERY OR CREMATORI

Popular Springs Cemetery

23d. LOCATION (City, town or county)

Howard Co.

(State)

Md.

24. FUNERAL DIRECTOR'S SIGNATURE

Harry W. Haight

ADDRESS

Sykesville, Md.

25a. REC'D BY REGISTRAR

FEB 3 1966

25b. REGISTRAR'S SIGNATURE

George J. H. Haight

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. Page 4 to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)								
a. COUNTY Howard			a. STATE Maryland								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ellicott City			b. COUNTY Howard								
c. LENGTH OF STAY IN 1b 8 yrs.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Ellicott City								
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS 25 Normandy Drive								
3. NAME OF DECEASED (Type or print) Melba			First	Middle	Last	4. DATE OF DEATH January 8	Month	Day	Year	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F			6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 22, 1921	9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours	13. IF UNDER 24 HRS Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY Telephone Co.			11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME late Paul Sweetman			14. MOTHER'S MAIDEN NAME Mildred Williams			Address					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO. 216-14-0635			17. INFORMANT Charles Gordon 25 Normandy Drive					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Carcinoma of the Breast			INTERVAL BETWEEN ONSET AND DEATH 3 mos								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>65</u> , to <u>8 Jan</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>6 Jan</u> 19 <u>66</u> , and that death occurred at <u>8 AM</u> , from the causes and on the date stated above.											
22a. SIGNATURE George J. Richards Jr.									22b. DATE SIGNED 10/10/66		
22c. PHYSICIAN'S NAME (Type) George J. Richards Jr.			22d. ADDRESS 101 Sunbury Rd Balt 12			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 11 '66			23c. NAME OF CEMETERY OR CREMATORIAL Crestlawn			23d. LOCATION (City, town or county) (State) Howard County, Md.		
24. FUNERAL DIRECTOR Harry H. Witzke 321 Columbia Pike			ADDRESS Ellicott City			25a. REC'D BY REGISTRAR DATE JAN 10 1966			25b. REGISTRAR'S SIGNATURE Charles J. Witzke		

112001

DRIVE

value education

etc. etc. etc.

etc. etc. etc.

etc. etc. etc.

etc. etc. etc.

1991.12.19.1

etc. etc. etc.

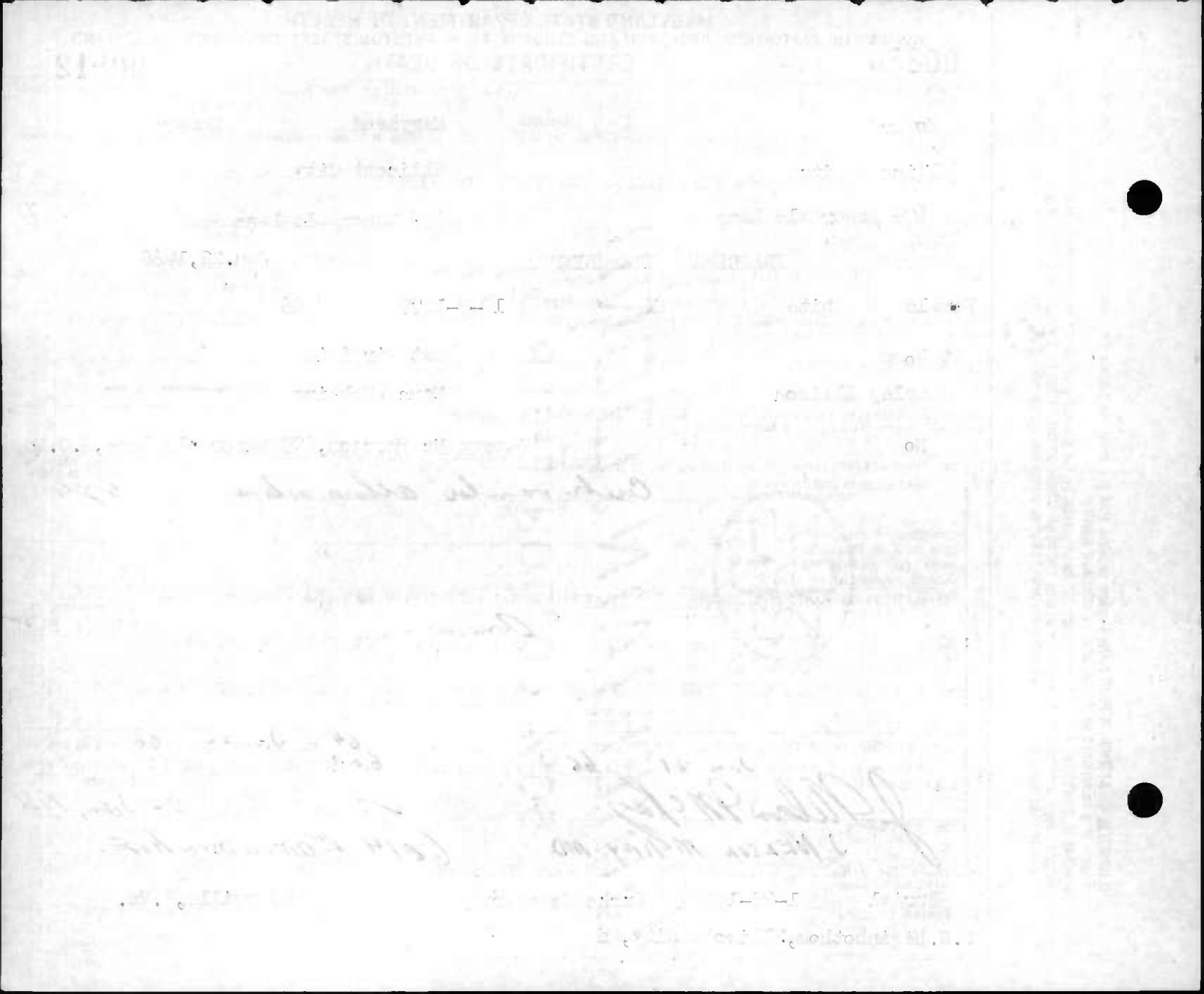
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1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
00830

CERTIFICATE OF DEATH
00812

1. PLACE OF DEATH a. COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 699 Manordale Lane		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 699 Manordale Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) FRANCENA		First	Middle	Last	4. DATE OF DEATH Jan. 22, 1966	Month	Day	Year
5. SEX Female		6. COLOR OR RACE White	7. MARRIED WIDOWED	8. DATE OF BIRTH 10-8-1879	9. AGE (in years last birthday) 86	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME Wesley Ellison		14. MOTHER'S MAIDEN NAME Nancy Dobbins						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ?		17. INFORMANT Geneva Mc Pherson, 699 Manordale Lane, E.C. Md		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 334X		OUE TO (b)		Cerebral vascular atherosclerosis		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		OUE TO (b)						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				Anemia.				
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Anemia.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Cedarville, W. Va.		(County) (State)
21. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on Jan 21, 1966, and that death occurred at 6:00 AM, from the causes and on the date stated above.						22b. DATE SIGNED 22 Jan, 1966		
22a. SIGNATURE J. Nelson McRay				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
22c. PHYSICIAN'S NAME (Type) J. NELSON MC RAY, MD		22d. ADDRESS 6014 Longmeadow Ave.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-25-1966		23c. NAME OF CEMETERY OR CREMATORIAL Burke Cemetery		23d. LOCATION (City, town or county) Cedarville, W. Va.		(State)
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		ADDRESS		25a. REC'D BY REGISTRAR DATE JAN 25 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
FOR STATE
HEALTH DEPT.

00831

00813

2
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

3
22 22 22

1. PLACE OF DEATH a. COUNTY HOWARD		MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODBINE		c. LENGTH OF STAY IN 1b 10 yrs.		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY HOWARD		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODBINE		d. STREET ADDRESS DAISY ROAD		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) CHARLES FRANKLIN HAIGHT		First	Middle	Last	4. DATE OF DEATH 1-23-1966	Month	Day	Year	5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCT 31, 1978	9. AGE (in years last birthday) 87 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. IF UNDER 24 HRS. Hours	13. IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY Farmer		11. BIRTHPLACE (State or foreign country) MILLVILLE N.Y.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) If yes give war or dates of service No		16. SOCIAL SECURITY NO. None		17. INFORMANT Muriel Knill, Woodbine Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4201		CORONARY THROAT BOSIS		INTERVAL BETWEEN ONSET AND DEATH INSTANT		Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) DUE TO ARTERIOSCLEROTIC C.V. DIS.		4 yrs						
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> George E. Burgtof		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> George E. Burgtof		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Charles H. Barber		DATE SIGNED 1-23-66										
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1-26-66		22c. NAME OF CEMETERY OR CREMATORIAL Oak Grove		22d. LOCATION (City, town, or county) Glenwood, Md.		(State)										
23. FUNERAL DIRECTOR ADDRESS Francis H. Barber Laytonsville, Md.		24a. REC'D BY REGISTRAR DATE JAN 26 1956		24b. REGISTRAR'S SIGNATURE Charles Judge														

Chenoweth, Bill

SEARCHED INDEXED SERIALIZED FILED
FEB 2 1967

Dr. ~~affiliated~~ ~~with~~ H. Stoen

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00832

CERTIFICATE OF DEATH

00814

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1		2. PLACE OF DEATH a. COUNTY Howard County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md.		b. COUNTY Balto.	
		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Zone 27		d. STREET ADDRESS 5558 Southwestern Blvd.	
		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Schaffer's Nursing Home						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Gustav	Middle H. Hobrock	Last Retired	4. DATE OF DEATH Jan. 4/66	Month Jan.	Dey 4/66	Year 19	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11/76		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Ind.	IF UNDER 24 HRS. Hours 3 days
10e. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Ind.		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Henry Hobrock		14. MOTHER'S MAIDEN NAME Sophia Christiner							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Frank Gettman, 5558 Southwestern Blvd		Address		zone 27	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (e) 443X		DUE TO (b) Hypertensive Cardio Disease		Cerebral Thrombosis		INTERVAL BETWEEN QNSET AND DEATH 3 days 7 years			
Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. } (c)		DUE TO (c) Illness							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)		20c. TIME OF INJURY Month, Dey, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan 3, 1966</u> to <u>Jan 4, 1966</u> that (I) (we) last saw the deceased alive on <u>Jan 3, 1966</u> , and that death occurred <u>1/15/66</u> from the causes and on the date stated above.		22a. SIGNATURE Eliot W. Johnson		ATTENDING PHYS. M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS 3432 Frederick Ave Baltimore, Md 21229 1/5/66							
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF JAN. 6/66		23c. NAME OF CEMETERY OR CREMATORIY St. John		23d. LOCATION (City, town or county) Decatur, Ind.		(State)	
24. FUNERAL DIRECTOR'S SIGNATURE Witzke F.D. 4101 Edmondson Ave.		ADDRESS		25e. REC'D BY REGISTRAR DATE JAN 6 1966		25b. REGISTRAR'S SIGNATURE Charles George			

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19. *Leucosia* *leucostoma* *leucostoma* *leucostoma*

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1. *Chlorophytum comosum* (L.) Willd. (Liliaceae)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00833

00815

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission) a. STATE		
Howard		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		
Jessey		3 Mo		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS		
Second Rest Home		Pindell Dr.,		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13-1		
3. NAME OF DECEASED (Type or print)	First	Middle	Last	
Ward Washington Jenkins			Jen	
4. DATE OF DEATH	Month	Day	Year	
Jan 3	Jan	3	1966	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	
Male	White	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	Jan 13, 1881	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country)	12. CITIZEN OF WHAT COUNTRY?	
Former general laborer add job	Washington	Washington D.C.	U.S.	
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	Address		
Alfred Jenkins	Emily Jenkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT		
no	213-12-1571	Mary Duvall Laurel, Md		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)				
1810 UREMIA				
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO (b)	2 weeks		
	DUE TO (c)	2 YEARS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				
CORONARY SCLEROSIS				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
19				
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 48</u> , 1966, to <u>JAN 3, 1966</u> , that (I) was last saw the deceased alive on <u>DEC 28 1965</u> , and that death occurred at <u>330 M</u> , from the causes and on the date stated above.	22b. DATE SIGNED			
22a. SIGNATURE Charles S. Whittaker	M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)	22d. ADDRESS			
CHARLES S. WHITTAKER, M.D.	CLACKSVILLE, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION (City, town or county)	(State)
Burial	1-6-66	Emmanuel Cem.	Scaggsville	Md
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE	
Walt W. Noraham	Second, Md	JAN 10 1966	Charles Judge	
VR A15 (4) 20M 1/65				

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7/61

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

00834

00816

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <input checked="" type="checkbox"/> Md. b. COUNTY <input checked="" type="checkbox"/> <i>Howard</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural - Woodbine</i>		c. LENGTH OF STAY IN lb <i>12 Years</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Daisy Rd.</i>		d. STREET ADDRESS <i>Daisy Rd.</i>	
3. NAME OF DECEASED (Type or print) <i>David Clinton Johnson</i>		First <i>Clinton</i>	Middle <i>Johnson</i>
4. SEX <i>Male</i>	5. COLOR OR RACE <i>Col.</i>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH <i>2-9-1870</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Lawrence Johnson</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give rank or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i> 17. INFORMANT <i>Mr. Herbert Hareday - Woodbine, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		Address INTERVAL BETWEEN ONSET AND DEATH <i>Several years</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4500</i>		Generalized Arteriosclerosis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)		DUE TO	
} (c)		DUE TO	
DUE TO		DUE TO	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(e)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1955 to Jan 27, 1966 that (I) (we) last saw the deceased alive on Jan 19, 1966, and that death occurred at 6 A.M. from the causes and on the date stated above.		22b. DATE SIGNED <i>1/20/66</i>	
22a. SIGNATURE <i>W.B. Culwell</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <i>W.B. Culwell</i>		22d. ADDRESS <i>Mount Airy, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>1-22-66</i> 23c. NAME OF CEMETERY OR CREMATORIUM <i>Daisy Methodist</i> 23d. LOCATION (City, town or county) <i>Howard Co. Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Harry W. Haight</i>		25a. REC'D BY REGISTRAR DATE <i>JAN 25 1966</i> 25b. REGISTRAR'S SIGNATURE <i>Charles J. Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00835

CERTIFICATE OF DEATH

00817

1 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Howard</i>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Callicott City</i>		b. COUNTY <i>30-4</i>				
c. LENGTH OF STAY IN 1b <i>2 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Schoff's Nursing Home</i>		d. STREET ADDRESS <i>1532 Hollins St</i>				
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>Mr. Clarence</i>	Middle <i>E. Macke</i>	Last <i>Jan. 15/66</i>			
4. DATE OF DEATH	Month <i>Jan.</i>	Day <i>15</i>	Year <i>1966</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 2, 1894</i>			
9. AGE (In years last birthday) <i>71 yrs.</i>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Physician</i>	11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Md</i>			
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	13. FATHER'S NAME <i>John H. Macke</i>					
14. MOTHER'S MAIDEN NAME <i>Magdaline Lindauer</i>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes give war or dates of service) <i>332X</i>					
16. SOCIAL SECURITY NO. <i>66-00000-000</i>	17. INFORMANT <i>Bethel P. Macke, Box 105A, Md</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>	INTERVAL BETWEEN ONSET AND DEATH <i>1/13/66</i>			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. <i>General Arterio-Sclerotic Cerebral Thrombosis</i>	OUT TO (b) DUE TO (c)	<i>5 years</i>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Cerebral Thrombosis Complete Th. side hemiplegia & word of oxygen</i>						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>2/11/66</i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Baltimore, Md</i>	20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>6/13</i> , 19 <i>66</i> to <i>1/16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>1/13</i> , 19 <i>66</i> , and that death occurred at <i>6/13</i> , 19 <i>66</i> , from the causes and on the date stated above.	22a. SIGNATURE <i>Elmer W. Johnson</i>					
22b. DATE SIGNED <i>1/17/66</i>						
22c. PHYSICIAN'S NAME (Type) <i>Witke F.H. 4101 Edmondson</i>	22d. ADDRESS <i>3432 Frederick Ave</i>	23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Jan 18/66</i>		23b. DATE THEREOF <i>Arlington</i>	23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS <i>Arlington, Va</i>	23d. LOCATION (City, town, or county) (State) <i>Arlington, Va</i>
24. FUNERAL DIRECTOR <i>Witke F.H. 4101 Edmondson</i>	25a. REC'D BY REGISTRAR <i>Charles Judge</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				
DATE JAN 17 1966						

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00836 110818

CERTIFICATE OF DEATH

Item #12 Film #3357 1/28/66

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Howard	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shaffer's Convalescent Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS 130 Dunloggin Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
f. ADDRESS 90		g. DATE OF DEATH January 22 1966		h. DATE OF BIRTH May 3, 1876		i. AGE (In years last birthday) 89 yrs.		j. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
3. NAME OF DECEASED (Type or print) Kalman		First M		Middle W		Last Mako		4. DATE OF DEATH January 22 1966	
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 3, 1876		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Fabrica		11. BIRTHPLACE (County & State, or foreign country) Hungary		12. CITIZEN OF WHAT COUNTRY? U. S. A.			
13. FATHER'S NAME Janos Mako		14. MOTHER'S MAIDEN NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 057-03-9697		17. INFORMANT Mr. Dave Mako 130 Dunloggin Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221		Cerebral Vascular Occlusion		INTERVAL BETWEEN ONSET AND DEATH 24hr.			
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.		DUE TO (b)		Arterosclerotic Cardio-Vascular Disease		10 yrs			
		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-1, 1966, to 1-22, 1966, that (I) (we) last saw the deceased alive on 1-2, 1966, and that death occurred at 7 th M, from the causes and on the date stated above.									
22a. SIGNATURE Thomas F. Herbert		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1-22-66			
22c. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.		22d. ADDRESS 44 Church Rd. Ellicott City, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF Jan. 24 1966		23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park		23d. LOCATION (City, town or county) Baltimore Md.			
24. FUNERAL DIRECTOR Harry H. Witzke 321 Columbia Pike		ADDRESS Ellicott City		25a. REC'D BY REGISTRAR JAN 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			
VR A15 (4) 20M 1/65									

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FOR STATE
HEALTH DEPT.

EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00819

1. PLACE OF DEATH a. COUNTY Howard			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			c. LENGTH OF STAY IN 1b MARYLAND			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland			b. COUNTY Howard			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 113 Fels Ave.									c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			13-1			
3. NAME OF DECEASED (Type or print) CHARLES THEODORE MARTIN			First	Middle	Last	4. DATE OF DEATH 1-3-1966	Month 19	Day 19	Year	d. STREET ADDRESS 113 Fels Ave.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED WIDOWED	NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1896	9. AGE (In years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. IF UNDER 24 HRS. Mins 0					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) Phoenix, Md			12. CITIZEN OF WHAT COUNTRY?						
13. FATHER'S NAME Joshua T. Martin			14. MOTHER'S MAIDEN NAME Frances Mc Cauley			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 215-10-5550 17. INFORMANT Mrs. Hildreth Cross, 11 N. Avoca Ave. E.C. Md			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis												INTERVAL BETWEEN ONSET AND DEATH Instant			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			DUE TO DUE TO DUE TO												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)												
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)						
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <i>George E. Burgtof</i>									CHIEF MEDICAL EXAMINER <input type="checkbox"/>						
EXAMINER'S NAME (Type) George E. Burgtof M.D.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						22. DATE SIGNED 1-4-1966						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 1-6-1966			23c. NAME OF CEMETERY OR CREMATORIAL Good Shepherd			23d. LOCATION (City, town or county) Ellicott City, Md			(State)			
24. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md			ADDRESS			25a. REC'D BY REGISTRAR JAN 6 1956			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>						

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00838 00821

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Marriottsville		c. LENGTH OF STAY IN 1b MARYLAND	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Albeth Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS 8820 Lakewood Road	
3. NAME OF DECEASED (Type or print)	First CLARENCE	Middle WALTER	Last PEDDICORD	4. DATE OF DEATH Jan. 11, 1966	Month Day Year 19 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 30, 1897	9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR Months Days Hours Yrs. 03 - 2
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salvage Worker - Retired		10b. KIND OF BUSINESS OR INDUSTRY Chev. Motors		11. BIRTHPLACE (State or foreign country) Frederick Co., Md.	
13. FATHER'S NAME George Clinton Peddicord		14. MOTHER'S MAIDEN NAME Julia Ann Moxley		12. CITIZEN OF WHAT COUNTRY? Albeth Road	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Arthur W. Schafer Merriottsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Thrombosis				INTERVAL BETWEEN ONSET AND DEATH Instant	
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Vascular Disease				4 years	
DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hollicott City, Md	(County) Howard Co., Md
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
CHIEF MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <i>George E. Burgtof</i> M.D.					
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22. DATE SIGNED 1-11-1966					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1 - 14 - 66	23c. NAME OF CEMETERY OR CREMATORIUM Meadowridge Mem. Pk Cemt. Howard Co., Md.	23d. LOCATION (City, town or county) Hollicott City, Md	
24. FUNERAL DIRECTOR Wm. J. Tickner & Sons		ADDRESS Baltimore, Md. 17	25a. REC'D BY REGISTRAR Charles Judge	25b. REGISTRAR'S SIGNATURE Charles Judge	
			DATE JAN 13 1966		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												00821
CERTIFICATE OF DEATH												
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)						
a. COUNTY		MARYLAND				e. STATE		b. COUNTY				
Howard						Maryland		Howard				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				
Marriottsville						Marriottsville		13-1				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year				
Marvin			B	Peddicord	Jan	22	1966					
5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					
Male		White	WIOOWEO <input type="checkbox"/>	Divorced <input type="checkbox"/>	Mar 19, 1887	78	78 yrs.	Months	Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?			
Retired			Farming			Baltimore, Md						
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address						
Charles Peddicord			Emily Weiderman			Mrs Mora Peddicord, Marriottsville Md						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
No			?			?			PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO (b)			A. Coronary Occlusion			INTERVAL BETWEEN ONSET AND DEATH 30 months			
4201			DUE TO (c)			Atherosclerotic Cardiovascular Disease			14 yrs.			
Generalized Atherosclerosis						Diabetes mellitus			20 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED?
20a. ACCIDENT WAS UNDERRLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year			20d. INJURY OCCURRED			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)			
Hour a.m. p.m.			White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
19												
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 19, 1965</u> to <u>Jan 22, 1966</u> , that (I) <u>last</u> saw the deceased alive on <u>Jan 20, 1966</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.												22b. DATE SIGNED
22a. SIGNATURE <u>Saai Okutman</u>												22b. DATE SIGNED <u>1-22-66</u>
22c. PHYSICIAN'S NAME (Type)			M.D. ATTENDING PHYS.			M.D. DIRECTOR			STAFF PHYS.			
Saai Okutman												
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City, town or county)			(State)
Burial			1-25-1966			Mt. View			Alpha, Md			
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			
F.C. Higinbotham, Ellicott City, Md						DATE JAN 25 1966			Signature			
VR A15 (4) 20M 1/65												

